

**ENROLLMENT**

240 Venture Circle  
Nashville, TN 37228-1699  
Telephone 615-255-3175

**GROUP 1500**
**RETIREMENT DATE**

FIRST NAME												MI	LAST NAME											

STREET ADDRESS																							
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CITY												STATE				ZIP			
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SOCIAL SECURITY NUMBER						DATE OF BIRTH mm/dd/yy		M	F	PHONE NUMBER			
-	-					/	/			(	)	-	

Please list the dependents that you wish to be covered below.								Email address:			
FIRST NAME & M.I. (LAST NAME IF DIFFERENT)							SEX		BIRTH DATE		
							M	F			
SPOUSE:									/ /		
CHILD:									/ /		
CHILD:									/ /		

**PAYMENT OPTIONS**

		Check One	Special Instructions *Monthly bank draft and credit card deductions are made on the 24 <sup>th</sup> of each month
	01	TVARS Deduction- monthly	None
	02	* Bank Draft- monthly (\$1.00 per transaction)	Complete Direct Debit Application
	03	* Credit Card- monthly (\$1.00 per transaction) Circle One VISA Master Card	Account Number Exp Date
	04	Annual Premium Single- \$ 351.96 Family- \$ 915.00	Send check with enrollment form Make payable to Delta Dental Plan of Tennessee

**IF YOU DROP COVERAGE, YOU MAY NEVER RE-ENROLL**

I agree to make the required contribution. I certify that the information contained in this form is true and correct to the best of my ability.

Signature:

Date:

For Delta Use Only	E.D.
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